AIR THOUGHTS
African Institute for Integrated Responses to VAWG & HIV/AIDS
Issue 2, May 2015

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"What *is* trauma"? asks Johanna Kistner, reflecting on years of clinical work responding to the distress caused by political, economic and social upheaval on the African continent. She contrasts the rigidity and simplicity of diagnostic 'tick boxes' with the complexities of lived experiences of conflict, violence and marginalisation. Through the reflections of her colleagues and the story of her client Josie she raises questions about practitioner-client relationships, definitions of trauma and healing, and confronting the dynamics of inequality and injustice that instigate and perpetuate mental and emotional distress.

» about the author

Johanna Kistner is a clinical psychologist by training and a street psychologist by passion and experience. She is the director of Sophiatown Community Psychological Services (SCPS), an organization that provides a range of innovative psycho-social services to marginalized children, families and communities in and around Johannesburg. In the early 90s she was instrumental in establishing the Ekupholeni Mental Health and Trauma Centre in the volatile townships to the east of Johannesburg. In 2006 she took over the leadership of SCPS, which has transformed from a small counselling organization into a major service provider focusing on refugees and migrant communities in the inner city, and HIV/AIDS affected communities in and around Soweto. SCPS is increasingly recognized for its emphasis on "strengthening the wounded carer" at all levels of care giving, and for its contribution to critical debates about the relevance of Western psychological and psychiatric constructs to African realities.

From personal tragedy to global responsibility:

Re-politicizing trauma work in an African context[1]

BY JOHANNA KISTNER

This article is not aimed at defining trauma, but rather at generating further questioning, in the interest of deepening our thinking and feeling as front-line carers and activists. Definitions of trauma, traumatic stress, post-traumatic stress and complex traumatic stress abound in the academic and medical literature.[2] The problem with these definitions is not that they do not have their use, but that they have been developed in certain contexts, often far removed from those in which they are eventually applied, and that they tend to squeeze physical, emotional and interpersonal events into tiny, usually medicalised, tick boxes, which then negate the totality and uniqueness of the lived experience of each human being within her particular social-political, cultural and economic context.

Thus Post Traumatic Stress Disorder (PTSD) has become a psychiatric (and by implication, medical) disorder, which a person exposed to an event judged by others as traumatic, either does or does not suffer from. The decision as to whether a person suffers from PTSD is made by a highly trained specialist. When the complexities of people's lives and experiences confront us as specialists with the fact that maybe not everything fits into the box of PTSD, we create another one—and this time we call it *Complex* Post-Traumatic Stress Disorder, with a longer list of symptoms that we tick off before announcing our expert opinion.

The word trauma itself comes from the medical world—we all know about trauma units in hospitals in which those with gunshot wounds, or injuries from accidents are treated. The assumption is that emotional trauma is akin to physical trauma—it can be observed, diagnosed and treated.

Diagnosis and treatment—therein lies our power as specialists, the special skills that separate us from our patients or clients, that draw the

1 This article was adapted from a presentation given at Johanna Kistner at *(Re)conceptualizing Trauma,* a convening organized by AIR in Kigali, Rwanda, 22–24 September 2014.

2 See Zondi, M. (2014, September). Breaking the walls of trauma counselling: A critical analysis of the models and diagnoses of trauma on the basis of our work at the Sophiatown Community Psychological Services, Johannesburg—South Africa. *AIR Thoughts*. (1).

line between us (who are in control) and them (who are not) and the seemingly necessary imbalance of power that is so characteristic of medicine and the science of healing. At the moment of writing this paper, my 14-year-old daughter is seriously ill in hospital, with uncontrolled seizures and a high temperature. After four weeks of pricking, prodding, measuring, and scanning, there are no answers, only more questions. And when the experts cannot find answers they tend to resort to the only other avenue open to them to preserve their status: blame the victim. And so at various points in the past month or so, it has been implied that my daughter and/or I have brought on the seizures and the fever on by ourselves—it is for secondary gain, attention seeking, or at best some kind of unconscious dissociation from unbearable circumstances at home or at school. Professional helpers seem to find it impossible to survive (or even thrive) in the realm of "not knowing."

In diagnosis and treatment and in the successful recovery of the patient lies the "feel good" reward for those of us who have chosen to work in the field of physical and/or emotional healing. And yet, it does not always happen this way, simply because the worlds of the people we want to serve are so much more complex. An individual tragedy is never just that. A traumatic event is never just an event. It is the result of a complex set of interactions between the personal and the collective, between the individual and her social context, and in the end it is always and inevitably a series of events shaped by economic and political imbalances of power—from the position of a woman or child in her family and community to the ruthless plundering of entire continents by a handful of global superpowers.

By reducing people's suffering in the face of war, violence, man-made disease, and economic deprivation to clearly define-able disorders, we are perhaps trying to obtain for ourselves at least a measure of control over realities which otherwise seem unbearable. There is no doubt that there is a place for this. An army of emotionally overwhelmed carers and healers will not be able to hold the hand and heart of this brutalized woman or that dying child. But if we are not careful, we are dangerously at risk of losing our own humanity in the maze of tick boxes and with it our capacity to fully feel and engage with both the desperate pain and the desperate courage of another human being. And if we cannot feel it, how then can we advocate for social change, for the transformation of our world into a more just and equitable one?

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Feeling it, becoming part of another person's experience of unspeakable horror, seems to be what we are most afraid of. And so even our attempts to deconstruct the medical language of trauma and trauma management, we substitute words that protect us, and possibly the client from the worst of the unbearable.

Developing our own definitions

In preparation for this presentation we asked the team at Sophiatown Community Psychological Services, where I work, to define the concepts of "trauma" and "trauma counselling" without using any technical or professional jargon, hoping that we could find words for the immense suffering and distress we witness daily in people who would otherwise be referred to as traumatized. In the brief time we gave to this task, we were not very successful, as it seemed almost impossible for us as counsellors to separate ourselves from the prevailing discourse. So colleagues defined trauma as:

- Something that disrupts functioning
- A sad and difficult experience for which the person is not prepared and for which she has not developed any coping mechanisms
- An unexpected event that cannot be foreseen

We struggled as a team to differentiate between trauma as an event, and trauma as an emotional response to an event. Moreover, trauma was mostly defined as a single event or experience, and there was little or no reference to the context within which such events or experiences take

place. Trauma counselling was seen, as it in the main discourse, primarily as an attempt to get the clients to "come to terms" and "accept" what has happened and to restore a sense of "normality".

Nevertheless, in the effort to capture the experience of trauma in our clients and our own as counsellors, a different language did tentatively emerge, suggesting perhaps the need for all of us to work on this more intensively over time:

- A cocktail of circumstances that leave a person vulnerable and without solutions
- Brokenness
- Disabled
- Shaken
- Becoming new in a way that nobody can understand
- Searching for something worth living for
- Holding the client's hand until she is able to walk on her own again

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Landscapes of suffering

In my view, there is a profound problem in transferring an understanding of trauma derived from assumptions based on Western contexts to those of African conflict and post-conflict societies. In very simple terms it seems to me that our models of trauma and trauma counselling are based on the assumption (which probably holds true for societies who have experienced lengthy periods of peace and prosperity) that bad things happen to good people sometimes. When bad things happen to good people in these contexts, it is assumed that there are safe spaces in which the person can be held and supported until such time as they feel ready to continue on their life's journey, even if the experience takes them in a somewhat different direction.

In societies ravaged by violent conflict (which inevitably involves the exploitation of economic resources for personal and political gain) bad things happen to good people all the time. In these contexts we cannot assume that people's lives follow a more or less predictable path, with more or less equitable access to educational and economic opportunities, and little risk of violent disruption. Events we would define as traumatic happen all the time, and very few people have the comfort of a safe space to retreat into for emotional containment and healing.

In the words of one mother of three who has never experienced any period free of violent conflict and has been through such unspeakable horror that she can only express her feelings through periodic retreats into psychosis:

They have born us into war and war it still is now. All my life there has been war in my province. We are born into war and the war does not stop.

For this woman, as for most of those we work with, there has never been a safe space to retreat to. Even as refugee in South Africa, she is one the run from one experience of violence to another, exacerbated by extreme poverty and the lack of any social or familial support system. In situations of on-going conflict the assumption of safe spaces does not hold. A more appropriate assumption is that of the "landscape of suffering", a term coined by psychotherapist working with victims of political persecution in Zimbabwe. It is landscape in which people move from one experience of horror to another, in which the development of identities and social networks is continually disrupted and in which there are few, if any, safe spaces in which emotional refuelling can take place.

Moreover, the Western trauma model assumes that people who have been through experiences of violence and horror have the material resources needed for survival, while they go through the process of healing. Again, this does not hold true in our context. For the vast majority of people whose lives and identities have been affected by the horrors of violence and war, the very basis of physical existence—food, shelter, health care—is continually under threat. It is this continued threat to basic survival that exposes people to further experiences of violence and

exploitation, and thrusts the "broken-ness" of personal and collective identities into the next generation.

> **"In situations of on-going conflict the assumption of safe spaces does not hold. A more appropriate assumption is that of the "landscape of suffering.'"**

The language of healing

There is another set of questions that continue to challenge the assumptions underlying my professional training and practice. These questions relate to the language of healing. What do we mean by the notions of "healing", "recovery", and "normal functioning"? Where and with whom does the power of healing lie? Is a return to a semblance of normality equivalent to healing?

In an effort to come to terms with these and related questions, I have read countless stories and accounts of survivors of Nazi ghettoes, and/or concentration and extermination camps, some also of their children. Interestingly, almost all of these seem to have been written by now elderly women, trying to capture the experiences they survived against all odds as children, teenagers, or young adults. Most of these women had eventually reached some place of physical safety, often in the USA, had reached a certain level of prosperity, raised families and come to lead seemingly normal middle-class lives. And yet between the lines, the psychological, emotional, and spiritual wounds inflicted on them by the most brutal death machine of all times are festering with an anguish beyond understanding, beyond the reach of all the psychotherapeutic tools available, bleeding wordlessly, unconsciously, into the next generation and the next.

> **"Josie teaches me that trauma cannot be sanitized by medical jargon (Complex Post-Traumatic Stress Disorder), psychotherapeutic mystification ("normalizing traumatic stress reactions") or popular sentimentality ("God will help you through this.")**

Dialogue with Josie

These questions bring me to Josie, a 25-year-old woman from the Democratic Republic of Congo. Just about two years ago, she was the oldest daughter in an ordinary family, living what seemed to be ordinary lives of a child whose father is employed by the military, moving from one military base to another, longing to stay in one place long enough to complete her education. Three months after the family moved to a conflict hotspot, the base was attacked by rebels.

I cannot take the story that Josie is beginning to share with me in the trusted space of our relationship, to "supervision" with more learned colleagues outside of the organisation, because I am told, it "traumatizes" them too much. But here, in Rwanda, across the border, from the last place Josie called home, it can be acknowledged and known as one of many, and the questions it raises for me as Josie's therapist/carer can perhaps be safely asked (acknowledging that carers needs safe spaces too).

After days on the run, stepping over dead bodies, waking up in make-shift shelters next to decaying corpses, Josie's family was caught and her father was ordered to kill his wife and children. When he refused, he was dismembered alive in front of his family. Josie was able to describe this in minute details—the cutting off of ears, arms, legs. When she last caught a glimpse of him he was not yet dead. The rebels took her five-year-old brother by his arms and legs and cut him into two with a machete. They raped her 17-year-old sister and shot her through the vagina. She died immediately. They ordered the 16-year-old brother to join them, and when he refused they beat him up badly. She thinks he cannot have survived the blows, but she did not seem him die, as she was bundled into a car and taken into the forest with a whole group of other women. She has not yet told me what happened to her mother on that day. In the forest she and the other women became "wives" to the militias. Women who objected were killed. Josie witnessed women's heads being submerged in boiling water until they died. Finally, she escaped, on her own, running aimlessly through the forest for three days, oblivious to hunger, thirst, or exhaustion, until she met up

with another group of people on the run. An elderly man and his family took her under their wing.

They eventually reached a village, and managed to alert the authorities. She was taken to the south of the country and had surgery for the internal injuries she obtained from multiple violent rapes. She then made her way to South Africa with her new "adopted family". The adoptive father was killed on in a car accident on the way to Home Affairs to apply for asylum. His wife could no longer take care of Josie and so she ended up in the arms of a man who gave her shelter and made her pregnant, before abandoning her. When we first met, Josie was eight months pregnant, living with another woman, who had taken her in but had few resources of her own. When the baby was six months old, she told Josie that she could no longer support her and her child and left the room they shared. Unable to pay the rent, Josie moved into a shelter for refugee mother and their children, where she can stay for six months, the assumption being that in this time she needs to get her life together enough to independently support herself and her children.

Josie tells her story in brief spurts. Both she and I are careful about how much we can handle. Sometimes our sessions are followed by what would be called "psychotic episodes". Her past becomes her present, she screams, and runs, and clings to her baby, crying that "they are coming for us, they are coming for us." She is telling us through these episodes that her past is her present, that it cannot be escaped from, even when she manages to pass as "normal." Her baby cries all the time she is separated from her mother. Josie's wounds are seeping into her little being, shaping the unconscious mind, preparing it to hold her mother's anguish, before she even has had a chance to develop a sense of self.

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The power of presence

Josie has enormous courage. She knows deep within herself that she needs to share the unbearable if she is going to survive at all. In the journey we are travelling, she is my guide. I am anything but the expert. I follow her where she needs to go. My contribution as her companion on this journey lies in being comfortable with the not knowing where we are going or what she is going to confront me with next. Sometimes, she is ready to take me into the next horror, challenging me to experience it as fully as humanly possible, but sometimes I resist, ill-prepared for the emotional overload. Sometimes we walk into other pasts, and she teaches me how to stand in for the mother who is no longer there. But always, always she confronts me with questions about the nature of "trauma" and the practice of "trauma counselling."

Josie teaches me that trauma cannot be sanitized by medical jargon (Complex Post-Traumatic Stress Disorder), psychotherapeutic mystification ("normalizing traumatic stress reactions") or popular sentimentality ("God will help you through this.")

Josie makes me question too whether there are times or situations when it may impossible to find words for the unspeakable, as much as they may have value in sketching the broad outlines of a horror too deep to grasp fully. She makes me aware that healing is an elusive concept which we can never hope to fully attain.

Perhaps much more important than the pursuit of words (or other forms of expression) in the interest of healing, is the power of presence, a presence that is fully aware of both self and the other. A presence too that is cognizant of the global struggles for power and money that have so profoundly violated this one life, and thereby the humanity in all of us. In the end, any framework for reconceptualizing trauma needs to integrate fully the recognition that in many societies bad things happen to good people all the time, because somewhere in the global halls of power they are purposefully made to happen. And since, for the lack of a better word at this stage, trauma is largely man-made, presence needs to be transformative both in the intimacy of the caring relationship, and in the pursuit of social justice.

AIR: African Institute for Integrated Responses to Violence Against Women & Girls and HIV/AIDS

AIR strengthens and shares transformative feminist approaches to violence against women and girls, HIV/AIDS and emotional well-being and mental health in the African region. We do this by supporting documentation, critical thinking and analysis, providing technical support and facilitating exchange amongst African practitioners, and increasingly the visibility of transformative approaches.

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